ATTACHMENT PART 3

REPORT OF MEDICAL EXAMINATION

		TIET OTT OF MIEDI	CAL EXAMINATION	
1. LAST NAME—FIRST NAME—MIDDLE NAME WOVE MY	VON		2. GRADE AND COMPONENT OR PO	3. IDENTIFICATION NO. 05967-084
4. HOME ADDRESS (Number, street or RFD, city by	Nown, State and ZIP (Ade)	of 11, Laur	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
8906 AACOO L	N DN	7798	biennies	12/2/12
7 SEX 8 880F/	a TOTAL VEADS	GOVERNMENT SERVICE		(700)
may Thank	· MILITARY	- CIVILIAN		ANIZATION UNIT
12. DATE OF BIRTH 13. PLACE OF B	IRTH	/ -	14. NAME, RELATIONSHIP, AND ADDI	RESS OF NEXT OF KIN WOTHER
- 7/1/80	ware	enyton, P	Same (301)	669-9352
16. EXAMINING FACILITY OR EXAMINER, AND ADD	et Ion		16. OTHER INFORMATION	
17. RATING OR SPECIALTY		<u>.</u>	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS
CLINICAL EVALUATIO	A	NOTED (December 2)		
NOR- (Official sach Item in appropriate polumn, en				n number before each comment. Continue in
MAL evaluated.)	MAL	ulnalllo	regar on the re	reliveratives airect
		- programa		an en el a lancio alla
19. NOSE		WHAN Rell	. M. O. S ME X	con to a, morale
20. SINUSES				
21. MOUTH AND THROAT		10 tendu	- 4	
22. EARS—GENERAL (INTERNAL CANALS) (Auchin mounts under terms 70 and 1	ory Ti			
26. DRUMS (Perforation)			n sa da	cated-see back.
24. EYES—GENERAL (Visual acuity and retract under items 59, 60 and to	lon .	10 eu - 2	ne avalle alle	sall - sel our.
28. OPHTHALMOSCOPIC	20			11/1/10
- M		Alicant &	es leader to	$C_{N}(n)$
(FURILS (Equality and reaction)		The contract of		o
27. OCULAR MOTILITY (Associated parallel mover	ments nystegmus)		10-00	
29. LUNGS AND CHEST (Include breasts)		1 a sulles	rete & Aleglin Remonulan	-
29 HEART (Thrust, size, rhyhm, sounds)		May Com		
30. VASCULAR SYSTEM (Varicoshies, etc.)			/	•
31. ASDOMEN AND VISCERA (Include hemia	,	10000	Bellion Alle	
32. ANUS AND RECTUM (Hemorrholds, Fistulae	, E	zeptelle	acceptance and	<i>,</i>
33. ENDOCRINE SYSTEM				
34. QU SYSTEM				· •
36. UPPER EXTREMITIES (Strength, range of	metical			
36, PEET		0-1000	1/A	•
37 JOWER EXTREMITIES (Except feet) (Strength, range of n	otion)	good no		
38 SPINE, OTHER MUSCULOSKELETAL		<i>y</i>)		
39 HOENTIFYING BODY MARKS, SCARS, TA	1700S	V		
40 SKIN, LYMPHATICS			•	
NEUROLOGIC (Equilibrium tests under item	1 72)	i i		
42 PSYCHIATRIC (Specify any personality dev	iation)	•		
43. PELVIC (Females only) (Check how done)		•		
☐ VAGINAL ☐	RECTAL		(Continue in item 73	1
44. DENTAL (Piace appropriate symbols, shown in examp	Nes, above or below numbe	or of upper and lower teeth.)	······································	S AND ADDITIONAL DENTAL
0			DEFECT	S AND DISEASES
1 2 3 Restorable 1 2 3 32 31 30 Teeth 32 31 30	restorable 1 2 32 31	o missing 1 2 3	Replaced (X) Fixed by 1 2 3 Partial	
32 31 30	teeth 32 31	30 Teeth 32 31 30 x, x x	Dentures 32 31 30 dentures	
1 1 2 3 4 5	6 7 8	9 10 11 12	13 14 15 16 E	
G 32 31 30 29 28	27 26 26	24 23 22 21	20 19 18 17 F	
т .			Ŧ	•
		LABORATORY	FINDINGS	
45. URINALYSIS: A. SPECIFIC GRAVITY			46. CHEST X-RAY (Place, date, film number and re-	sult)
B. ALBUMIN	D. MICROSCOPIC			•
C. SUGAR	1			
47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH	50. OTHER TESTS	
		FACTOR	on other regio	
		1		
		1		
	1	<u> </u>		

51. HEI	Ce	ase 1	1:04-cv-	000	11-S	JM-S	PB MEM	SURFIMENT	S AND	OTHER E	N BING	9 2/1	5/200	26	Pac	ne 3.0	f 41		
51. HEI	знт С :	52	z. WEIGHT		53. COLO	DA HAIR T	54. COLO	REYES	55. BUILD			1			_	, ,		PERATURE	
	<u>. Ч</u>		<u> </u>		Da	CK_	1 Bro	 		SLENDE	R	MEDIU	м	HEAVY		BESE	48	8	
57.	Fare		BLOOD PRESSU		at heart lev			58.					PULSE (Arm	at heart	level)				
A. SITTH		<u>(λφ</u> - 50	B. RECUMBENT	SYS.		C. STANDING (5 min.)	SYS.	A. SITTING		B. AFTER EX	ERCISE	C. 2 M	IN. AFTER	D.	RECUMBE	ENT E	E. AFTE 3 MIN	R STANDING	
59.		DISTA	NT VISION	·		60.		REFRACTION	v			81.			N	IEAR VISION			
RIGHT 20	200		CORR. TO 20/			BY	S.		cx			 		COI	RR. TO			BY	
LEFT 20/	30	C	CORR. TO 20V		Ī	BY	s.		СХ						RR. TO			BY	
	EROPHORIA	(Specify	distance)									·							
ES*			EX*		R.H.		L.H.		PRISM DI	v.		PRISM	CONV.		Р	c		PD	
63.		ACCOM	MODATION		1	64. COLOR	VISION (Test use	d and result)				PTH PER	CEPTION		UNC	CORRECTED			
RIGHT		L	£FŢ			1sh	ham'	5-1007	Casa	ed 💮	760	st used a	na score)		COF	RECTED			
66. FIEL	OF VISION	V	· · · · · · · · · · · · · · · · · · ·		,	67. NIGHT V	ISION (Test used	and score)	 		68. RE	D LENS	TEST		69.	INTRAOCUL	AR TEN	SION	
70.		HEA	ARING			71,		AUDIOME	ETER		<u> </u>		72. PSYCI	HOLOGIC	AL AND P	SYCHOMOT	OR		·
RIGHT W	v ·		/15 SV		/15		250 500 256 512	1000 2000 1024 2048		4000 4096	6000 5144	8000 8192			<i>∞</i>	•			
LEFT W			/16 SV	•	″°	RIGHT LEFT			/ Xe	1	1	<u> </u>		•					
73 NOTE	S (Continued 00 11	n) and sk r (l./	GNIFICANT OR I	NTERVAL	L HISTORY	ttes	191	mlu	ly			Į				-			-
- 12	200	ν- _γ	we	ek o	1/1	de	na	M				•	÷						
		ju	1000 77	/ A	س. مدروا	G U	110	/					•					ď.	
- 4	lli	w	1 1	α				, 1		0	ola	1	PAI	41	ı relle	len		Beu	e
-(1	10.	11/4	1 Hel	pL	. U	Ce u	ear O	round	KY.	NO	X	<i>(^</i>	The same	Ν	ji J	,,	-		
	$\sim \omega$	אין קור	(0)		D	in A	n ha	uy	du	Signer	ŽU	ti	10 [17	103				
(Will	16	m	fung	ĺ	<i>Y</i>	$\gamma = \gamma$	•	•	- 4	1. 1	1.1	11	ef n	ومرح	le :	X/4	u.	6	
Moo .	1.11	ı alı	a lah	20	e n	~11	1 mt	le 1	ÚG	ur /	NO	C	7		- ()		,	, 0	
Joseph		1.				5-1	a fe	en Di					V			U			
	-U	<u> </u>	Mitte !	m	100	70	$\mathcal{O}(\mathcal{O})$	(Use addition	al sheets if	necessary)					i.				
74. SUMA	ARY OF DE	FECTS A	ND DIAGNOSES	(List dieg	gnoses witt	Alban numbe 	rs) //	ola.	15.	. /	n								
					- 1	\mathcal{U}_{i}	EM!	veca.	X			egi							
•						1	West	a del	"Ke	Arc	cet	1	_ د						
					-	19		addu		1-0		(n)	118	Ho)	nee	\mathcal{Q}_{l}			
						رجك	mk	adu	<i>א</i> קטע	uen	4,6		1000						
						" //	1//			•	/ '		-						
						U	V		.,										
76. RECO	MENDATIO	NS-FUF	THER SPECIALI	ST EXAL	HINATIONS	INDICATED	(Specify)			·		- 1	76.	A. F	PHYSICAL	PROFILE			
M	UM.	ni	Up	WY	nu	M	•						Р	ı,	TT	н	E	s	
	0	/	//									 		-		 			
77. EXAM	NEE (Check))	- 	1.		0.1.1	-A	1.1.	1	to A	Ber	1,	 						
	QUALIFIED		LIFIED FOR	Ú	ng	prie	uly	nec	eva	ted	مبر	7		8. Pl	YSICAL C	ATEGORY			
78. IF NO			SQUALIFYING DI	EFECTS	BY ITEM N	NUMBER					,	4	Á		.]	s			
70 TVDER	OR COINT	D MANE	OF PURPOSAN			·····		<u>. </u>			-11								
		į .	OF PHYSICIAN					,	SIGNA	IURE /	X								
80. TYPED	OR PRINTE	O NAME	OF PHYSICIAN			Laybou :1 Ollic			SIGNA	TURE #	10	7	m)			·		
81. TYPEO	OR PRINTE	D NAME	OF DENTIST OF						SIGNA	TURE	<u>"</u>	· • ·						•	
82. TYPED	OR PRINTE	D NAME	OF REVIEWING	OFFICER	OR APPR	OVING AUT	HORITY		SIGNA	TURE			• • •			NUMBER	OF ATT	ACHED SHEETS	
<u></u>		-				<u>-</u>		1 6 700, 1002				·					- 00 #	Day 2 001 1	

1. LAST NAME - FIRST NAME - MIDDLE NAME	3 Document 46-8 A Pile 102/15/2006 Page 4 of 41
Ward - Muran	2. GRADE AND C ENT OR POSITION 3. IDENTIFICATION NO.
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	1/359107-08
the state of the s	S. PURPOSE OF EXAMINATION 6. DATE OF EXAMINATION
	, Misical
7. SEX 9. TOTAL YEARS GOVE	1-25-0
7. SEX MILITARY	TA 11. ORGANIZATION UNIT
12. DATE OF BIRTH 13. PLACE OF BIRTH	TOWNER THE WORLD
	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
1110	
15. EXAMINING FACRITY OR EXAMINER, AND ADDRESS	
	16. OTHER INFORMATION
17. RATING OR SPECIALTY	
	TIME IN THIS CAPACITY (Total) LAST SIX MONTHS
CLINICAL EVALUATION NOT	FS: /Describe
NOR- (Check each from in appropriate column, enter TVE if not ABNOR- MAL evaluated.)	ES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)
18, HEAD, FACE, NECK AND SCALP	
19 NOSE	The following is a FOOD HANDLERS' PHYSICAL which
20. SINUSES	determines if and inmate is medically cleared from a
21_MOUTH AND THROAT	infectious disease, and is able to work in Food Committee
ZZ/ EARS-GENERAL MITERNAL CANALS (Auditory acuty south south y sinder shows 70 and 71)	determines if the inmate is free from: Acute an above
23. DRUMS (Perforation)	Mer C I milanimatory conditions of the respiratory greaters.
1	
25. OPHTHALMOSCOPIC	on the sand infection and/or communicable disease.
26. PUPILS (Equality and reaction)	RIA
	sintact
28. LINGS AND CHEST (Include breests)	LIMUIC
29. HEART (Thruss, size, rhyhm, sounds)	CIMONO
30. YASCULAR SYSTEM (Varicastias,etc.)	d Rules No Vancosi hui
31. ABDOMEN AND VISCERA (Include hornie)	SX4 Quads No MATO
32. ANUS AND RECTUM (Prostate, Fisher) (Prostate, Findcated)	
33. ENDOCRINE SYSTEM	
SYSTEM CTO OF	no amount of SII
35. UPPER EXTREMITIES (Strength, range of motion)	m Shength FS15 N Shength FS75
36. FEET	n shear un f STS
	11 Oloffat 310
38. SPINE, OTHER MUSCULOSKELETAL	
39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	- Avid - Out
	es. Note s Tajous
42. PSYCHIATRIC (Specify any personality deviation)	nons intact of becliremities
11 A 3. PELVIC (Females only) (Check how done)	
JA VAGINAL D RECTAL	
44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper	(Continue in item 73)
0	REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES
1 2 3 Restorable 1 2 3 Non- 32 31 30 Teeth 32 31 30 restorable 32 31 30 Te	sing $\frac{\hat{1}}{23} \frac{\hat{2}}{31} \frac{\hat{3}}{31} \frac{\text{Replaced}}{\text{DY}} = \frac{1}{1} \frac{\hat{2}}{2} \frac{\hat{3}}{3} \frac{\text{Fixed}}{\text{Fixed}}$
R 18000	32 31 30 Pertial X X X Denturos (X) denturos
G 32 31 30 30 30 37 57	10 11 12 13 14 15 16 E
H 22 31 30 29 28 27 26 25 24 2	23 22 21 20 19 18 17 F
	T
45. URINALYSIS: A SPECIFIC GRAVITY	LABOR TORY FIN INGS
B. ALBUMIN D. MICROSCOP	48. MEST X-RAY (Figure Ceste, Stim number and result)
C. SUGAR	
47. SEROLOGY (Specify test used and result) 48. EKG 49. BLO	LITPE AND 1 50 CHERITETE
FAC	
SN 7540-00-634-4038	
3-124	Standard Form 88 (Rev. 3-89)

Case 1:04-cv-00011-SJM-SPB Document 46-8 Filed 02/15/2006 Page 5 of 41 MEASUREMENTS AND OTHER FINDINGS 51. HEIGHT 52. WEIGHT 53. COLOR HAIR 54. COLOR EYES SE. TEMPERATURE SLENCER MEDIUM HEAVY 57. BLOOD PRESSURE (Arm at heart level) PULSE (Arm at beart level) SYS. SYS A SITTING E. AFTER STANDING 3 MIN. SITTING STANDING DIAS DISTANT VISION REFR NEAR VISION RIGHT 20 BY CORR. TO LEFT 20/ S. СХ CORR. TO ES PRISM DIV **63.** ACCOMMODATION 64. COLOR ION (Test used a TH PERCEPTION UNCORRECTED RIGHT LEFT CORRECTED 66. FIELD OF VISION 67. NIGHT VI (Test used and score) 68. RED LENS TEST 70. HEARING AUDIOMETER 72. PSYCHOLOGICAL AND PSYCHOMOTOF

(Tests used and score) RIGHT WV /15 SV RIGHT LEFT WY #15 SV LEFT 73 NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY **PPD Status:** 3-21-00 Results: CXR: (If applicable) Results **RPR Status:** Date: 5-10-90 74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item number The patient is able to work in Food Service: No The inmate received patient education and was advised to keep hands clean at all times while handling food, wear protective gloves when handling food, wash hands after using restroom and to report any suspicious rash or skin lesions, fever, night sweats or productive coughing to Health Services Staff. The patient voiced understanding of above 75. RECOMMENDATIONS - AUHTHER SPECIALIST EXAMINATIONS INDICATED (SPECIAL FOOD Service 77. EXAMINEE (Check) A D IS QUALIFIED FOR B. IS NOT QUALIFIED FOR 78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER 79. TYPED OR PRINTED NAME OF PHYSICIAN SIGNATURE Catherner PH 82, TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY SIGNATURE NUMBER OF ATTACHED SHEETS

MEDICAL RECORD		REPORT	OF I	MED	ICAL EXAN	MINATION		DATE OF EXA	M
1. LAST NAME-FIRST NAME-MIDDLE	NAME			2. 1	DENTIFICATION N	IUMBER	3. GRADE AND C	COMPONENT OR P	
Ward Muse	wi i				05967	7-087		COMPONENT ON P	DPHION
4. HOME ADDRESS Warnber, street or)	The gity of lown, s	tate and ZIP code)		5. E	MERGENCY CONT	ACT (Name and ac	dress of contact)		 -
		್ಳೇಕ			May 1	aniels			
Wheaten,	ω			1	7686	Fountant	The Pr		
	20902						gn, MD 20	-200	
6. DATE OF BIRTH	7. AGE 8	SEX		9. RI	LATIONSHIP OF	CONTACT	5131 W 20	764	
7/1170	2R 1	FEMALE DAMA	VI E	1	no 11				
10. PLACE OF BIRTH	1	1. RACE	7		moth	<u> </u>			
Washington, 1	2C- Ir	WHITE PABL	ACK	Г	AMERICAN IND			ASIAN/PACII	FIC
12a. AGENCY BOY	12	26. ORGANIZATION UNI			, ALDIOUVIER IN		OTAL YEARS GOVE		
FILC un box	la d	11. 1110				a MILITARY		CIVILIAN	
1 a ame	(grade)	HealthSur	16	ζ			,	CIVICIAIN.	
14. NAME OF EXAMINING FACILITY OR	EXAMINER, AND A				ATING OR SPECIA	L ALTY OF EXAMINE			
					DA/		•		
PAI A11	APSPER A & D	yang.		16. P	URPOSE OF EXAM	MOLTANIA			
ru cu	MBERLAN	U							
					intako	Physical			
		17 CU	NCIA	5//	LUATION	(·	
NOR- MAL (Check each item in appropria	te column, enter "N		ABNOR			itam in			12.27
A. HEAD, FACE, NECK AND SCAL			MAL			Over 40 or clinically	column, enter "NE" i	not evaluated.)	ABNO
, B. EARS-GENERAL (INTERNAL CA			ļ	HH.	P. TESTICULAR	Over 40 or clinically	indicated)		
	y under items 39 a.	nd 40)		2	 	FOTURA #			
C. DRUMS (Perforation)		V14-1/-		Ì			ids, Fistulae) (Hemoc	uit Results)	
D. NOSE					R. ENDOCRINE S	TSIEM	···-		
E. SINUSES				\leq	S. G-U SYSTEM	APTICA (O.			
← F. MOUTH AND THROAT				5	U. FEET	MITIES (Strength, r	ange of motion)	·	_
G. EYES-GENERAL (Visual acuity an	d refraction under	items 28 29 and 261		$\overline{\mathcal{X}}$		ENAPTIES (5			1
H. OPHTHALMOSCOPIC	d renderion under	Kems 28, 23, and 36)		~			et) (Strength, range o	f motion)	
1. PUPILS (Equality and reaction)				$\frac{\propto}{\sim}$		R MUSCULOSKELE			
J. OCULAR MOTILITY (Associated p	arellel movement	nunta amus l		<u> </u>	Y. SKIN, LYMPHA	BODY MARKS, SCA	IRS, TATTOOS		 _
K. LUNGS AND CHEST		nystagmus)		$\frac{2}{2}$			1 1		
CX. L. HEART (Thrust, size, rhythm, sou	nds!			3		(Equilibrium tests		· · · · · · · · · · · · · · · · · · ·	
M. VASCULAR SYSTEM (Vericositie					BB. BREASTS	C (Specify any perso	onality deviation)		┥—
X N. ABDOMEN AND VISCERA (Inclu			\dashv		CC. PELVIC (Fer	matan antul			
NOTES: (Describe every abnormality in det.		l item number before eac					of about 1		1
	•			,,,,,,,,	SOMMING IN NEW Y	2 and use addition	u sneets II necessar)	"	
		•							-
•									
				•					
	•								
18. DENTAL (Place appropriate symbols, shi	own in examples, a	bove or below number of	of upper	and lo	wer teeth.)		REMARKS AND AD	DITIONAL DENTAL	
0 /	Non- X	Y Y		eplace		Fixed .	DEFECTS AND DISE	ASES	
1 2 3 Restorable 1 2 3 32 31 30 Teeth 32 31 30	restorable 2 3	3 Missing 1 2 1 30 Teeth 32 31	3	by	7 2 3	Partial			
R 0 /	X		_X D	enture	* <u>* * * * * * * * * * * * * * * * * * </u>)entures			
$G = \frac{1}{3} + \frac{2}{3} + \frac{3}{5} + \frac{4}{5}$	6 7 8	9 10 11 -	12	13	14 15 16	L E	•		
H ³² 31 30 29 28	27 26 25	24 23 22	21 ;	20	19 18 17	F		•	
· · · · · · · · · · · · · · · · · · ·	19 TEST P	ESULTS (Copies o	from	ulto -	ra professor d	<u> </u>			
A. URINALYSIS: (1) SPECIFIC GRAVITY	io. itoi ni	LUCETO (COPIES C	n resu	CHES	X-RAY OR PPD	is attachment: Place, date, film nu	(a)	·	
2) URINE ALBUMIN	(4) MICROSCO	PIC	"			uere, imii nu	muer and result)		
3) URINE SUGAR	-	-							
SYPHILIS SEROLOGY (Specify test used	D. EKG	E. BLOOD TYPE AND R	H E	OTHE	RTESTS		····		
and results)		FACTOR	"' '	OTHE	11513				
	1		1			•		•	

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NAME (//Case 1:04-cy-0001	1-SJM-SPI	3 D	Ocur	men	F45	S9	N N	ed 02/3	15/2	006	Pa	ige i	7 (00). 4F	SHEETS A	TTACHE
		MEASL	JREME	NTS	AND	OTHE	R FII	NDINGS					<u> </u>	····	
20. HEIGHT 22. (3. COLOF			SUILD								25. TEMP	ERATURE	
010z 1616	place	bon	wn		O Str	ENDER		MEDIUM	Пн	EAVY	OR	ESE	9	75	
26. BLOOD PRESSURE (Arm a	t heart level)			!						m at he					
A SYS. //O B. SYS.	C. SYS.		A. SITT	ING	B. RE	CUMB	ENT	C. STANDI	NG				E. 2 MINS	AFTER	
SITTING DIAS. 16 BENT DIAS.	(5 mins.) DIAS	j	1	37				(3 mins	s. <i>)</i>						
28. DISTANT VISION		29	. REFRA	CTION	-1					L	20 NE	AR VIS	CION		
RIGHT 20/ Learly RESTO 20/	BY	S,			CX					CORR. T		AN VIS			
LEFT 20/ 7.0 CORR. TO 20/	BY	S.			CX								BY		
31. HETEROPHORIA (Specify distance)		~								CORR. T	<u> </u>		BY		
ESO EXO R.H.		. H .		PRIS	SM DIV			PRISM C				PC ;		PD	•
32. ACCOMMODATION	33. COLOR VISIO	N (Test	used and	result)	,			34. DEPTH		PTION	1				
RIGHT LEFT	†			•				(Test us	ed and	score)	-		RECTED		
35. FIELD OF VISION	36. NIGHT VISIO	N (Test u	sed and	scorei				37. RED LEI	NC TEC	r	- 0	ORREC			
RIGHT LEFT	1						[or neo cei	145 (25	•	-		INTRAO	CULAR TE	NSION
39, HEARING			40. AUC	IOMET				TAI DSVC	HOLOG	UCAL AR		IGHT	2700.47	LEFT	
	1 250 50		1			Τ	1	7	HOLOG	HUAL AP	ND P510	SHOME	JIOK (/es	sts used an	id score)
RIGHT WV /15 SV /15	250 50 256 51			3000 2896	4000	6000	8000	0							
	RIGHT	 -			-	-	- 1 - 1	-					-		
LEFT WV /15 SV /15	LEFT		 					-							
42. NOTES (Continued) AND SIGNIFICANT OR IN			<u> </u>				<u></u> ,,	<u> </u>							
DRUG HX FLEDOW PSH & MEDICATION ALCOHOL HX OTHER: SPECIFY & 43. SUMMARY OF DEFECTS AND DIAGNOSES (LA AUGHTER 1245 C Aughter 1245 C Aughter Weed	Subelow st diagnoses with i	farly	thear	rily		Necess.	ary)		-						
4. RECOMMENDATIONS - FURTHER SPECIALIST	EXAMINATIONS IN	DICATED) /Canad	E . 8											
		SOMIEL	- IODECIT	y 1				ļ	 _		15A. PH	YSICAL	L PROFILE	:	
								Р	U	L	Н	Ę	s		
6. EXAMINEE (Check)									<u> </u>				<u> </u>		
A. S QUALIFIED FOR WORL B. IS NOT QUALIFIED FOR										45	iß. PHY:	SICAL (CATEGOR	Y	
7. IF NOT QUALIFIED, LIST DISQUALIFYING DEFE	CTS BY ITEM NUM	BER													
								<u>-</u>	Α	8		c	E		
8. TYPED OR PRINTED NAME OF PHYSICIAN	tor nilva			e.	GNATU	IDE			Щ.						
DIWN WILLIAMS RY 9. TYPED OR PRINTED NAME OF SHYBIONARI CLINICAL E)IRECTOR	llia.	_a)			Kur	ein.	1	dn	20					
O. TYPED OR PRINTED NAME OF DENTISE VANDE				SIC	GNATO	<u>ハノン</u> RE	u	- 000 2		<u>~</u>		 ,			
1. TYPED OR PRINTED NAME OF REVIEWING OFFI	CER OR APPROVIN	IG AUTH	ORITY	Sic	SNATU	RE									



U.S. Department of Justice

Federal Bureau of Prisons

Federal Detention Center

P.O. Box 572 Philadelphia, Pennsylvania 19105

It is important that the BOP screen each newly committed inmate for communicable diseases. Each inmate is required to answer the following questions:

Es importante quel BOP examine a todos los reclusos y reclusas para las enfermedades contagiosas. Es requerido que cada reclusos y reclusas contesten las siguientes preguntas:

1. Do you have a cough? (Yes) No:	
If Yes;	

- How long have you had this cough? 4bout 110
- Does anything come up with this cough? NO
- Does your chest hurt with this cough? Secretion of
- 2. Have any of the following symptoms been present for at least three (3) weeks (circle yes or no)?

- fever Yes/No
- chills Yes/No
- night sweats Yes/No

- night sweats
- easy fatigability
- loss in appetite

Yes/No.

- more than ten (10) pounds weight loss Yes/No

I certify that the above answers are correct

- ¿Cuando tose algo sale con la tos?____

- ¿Su pecho duele con la tos?

2. ¿Algunos de los siguientes sintomas han sido presentado en las últimas tres semanas (marca si o no)?

- fiebre Si/No
- escalofifo Si/No
- sudor de noche Si/No

- se cansa fácil Si/No - pérdida de apetito Si/No

- ha perdido mas de diez libras

Yo certifico que mis respuestas artibas estan correctas

Myron Wow 10/21/03
Inmate Date

Reclusa/Reciuso

Fecha

SiMo

05967-084

Register Number

Numero de Registro

	(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)												
1. 1	LAS	T NAME	FIRST NAMEMIDDLE NAM	E			HT/509 WT/155 CUSTODY/IN				EY/BN		
3. I	PUR	POSE OF	EXAMINATION		4.	DA1	COSTODI/IN						
										U	cc lem		
6. S	TA	TEMENT	OF EXAMINEE'S PRESENT HE	ALTI	H Al	ND I					nt arises)		
							WARD						
1							MYRON ARVEL B/M/O/07-07-197	^		05967	7-084		
ĺ							HT/509 WT/155		HR/	BK E	EY/BN		
							CUSTODY/IN	_	,		-1/ 51		
7 10	7. HAVE YOU EVER (Please check each item) 8. DO YOU (Please check each item)												
YES				reck e		de annal		YES					
1 63	INC		with anyone who had tuberculosis	ieck e	ucn	iiemi)		TES	NU		(Check each item)		
<u> </u>	⊦┼	+				·		├ ─	X		lasses or contact lenses		
	-	+	ed up blood					ļ	X		ision in both eyes ligally hind		
\vdash	\rightarrow	_ֈ	scessively after injury or tooth extra			·· ·-		ļ			hearing aid the Residence		
\square	Ш	· · · · · ·	oted suicide					ļ	Н		or stammer habitually 0		
!		1 1	sleepwalker	(2)				<u> </u>	<u> </u>	Weara	brace or back support		
9. H	PONTE PONTE												
YES	NO	DON'T KNOW		YES	NO I	DON'T KNOW		YES	NO	DON'T KNOW	(Check each item)		
\vdash	+	 	Scarlet fever	ļ	-	1	Adverse reaction to serum drug		1		Epilepsy or fits		
-	{	+	Rheumatic fever	-	-		or medicine			ļ <u>.</u>	Car, train, sea or air sickness		
	-{	1	Swollen or painful joints	ļ	\vdash		Broken bones		H	-	Frequent trouble sleeping		
 	+	 	Frequent or severe headache		\vdash		Tumor, growth, cyst, cancer				Depression or excessive worry		
		<u> </u>	Dizziness or fainting spells	 -	+		Rupture/hernia		-		Loss of memory or amnesia		
O X			Eye trouble		4		Piles or rectal disease			 	Nervous trouble of any sort		
2	τ.	 	Ear, nose, or throat trouble		\dashv		Frequent or painful urination		{		Periods of unconsciousness		
	1	<u> </u>	Hearing loss		1		Bed wetting since age 12				Have you ever had		
	7	 	Chronic or frequent colds		+		Kidney stone or blood in urine		Į		homosexual contact?		
	V	-	Severe tooth or gum trouble	\Box	4		Sugar or albumin in urine		-		Been exposed to AIDS		
D		,	Sinusitis		+		VD—Syphilis, gonorrhea, etc.		1		Alcohol Use (Excessive)		
	X	+	Hay Fever		-		Recent gain or loss of weight		1	ļ	Drug Use/Addiction		
	\ \	-	Head injury		4		Arthritis, Rheumatism, or Bursitis		1		Marijuana		
	4	1	Skin diseases		+		Bone, joint or other deformity		1	ļ	Cocaine		
	+	<u> </u>	Thyroid trouble		+		Lameness		+		Heroin		
	1	1	Tuberculosis		+		Loss of finger or toe		-	 	L.S.D.		
$\langle \cdot \rangle$		 	Asthma				Painful or "Trick"shoulder or elbow		_		Amphetamines		
$\overset{\sim}{\sim}$	_	ļ	Shortness of breath		-{-		Recurrent back pain		1_		Others: (Specify)		
	X	 	Pain or pressure in chest		-		"Trick" or locked knee		+				
y'			Chronic cough		-	-	Foot trouble	l	1		Alcohol or drug		
	4		Palpitation or pounding heart		41		Neuritis		4	 	Withdrawal Problems		
	_]	Heart trouble				Paralysis (include infantile)						
	4	1	High or low blood pressure		_	· .							
	+	 	Cramps in your legs	_				10. F	EM/	ALES ONI	LY HAVE YOU EVER		
	1.		Frequent indigestion		_]			Been treated for a female disorder		
		 	Stomach, liver, or intestinal trouble								Had a change in menstrual pattern		
			Gall bladder trouble or gallstones								ARE YOU PREGNANT		
		<u></u>	Jaundice or hepatitis								SUSPECT YOU ARE PREGNANT		
11. W	/HA	T IS YOU	UR USUAL OCCUPATION?					12. A	RE	YOU (Che	ck one)		
Clerical Work								Right handed Left handed					
	<u> </u>	<u> </u>	VUV-1 DU VVI						-0"		-		

CHECK EACH ITEM YES ON NoAPY ITEM CHECKED YES MUST BE FINLY EXPLANATIONS OF BRANK SPACE BELOW YES NO 13. Have you been refused employment or been anable to hold a plan for one way as shooked because off in the complete of the part of the complete of the part of the complete of the part of the complete of the complete of the part of the part of the complete of the part of the part of the complete of the part o				0		7 110d 02/10/2000 1 dgo 10 01 11
13. Here you cent related employments or been unable to hold a place in place of any an shared because of the any any shared because of the any any shared because of the any any shared or any any shared or any any shared or any and any of present and any shared or any of present and any shared or a senate condition. 16. Here you cent been desired for a senate condition? If yes, specify when, where, and give desired. 20. Here you ever been rejected for military service because of specify when, where, and give desired. 20. Here you ever been rejected for military service because of specify when, where, and give desired. 20. Here you ever been rejected for military service because of specify when, where, and give desired. 21. Here you ever been desired life immuned? If yes, state reason and give desired or any operation of the state of the specify when the state of t			CHECK EACH ITEM YES OR NO JERY ITEM CHECKED Y	ES M	UST I	BE FULLY EXPLAINED IN BLANK SPACE BELOW
13. Here you see had any pilectic to layer from those statedy polynomials of the polynomial of the polynomials of the polynom	YES	NO		YES	NO	
B. Itability to perform certain anctions. C. Instillity to samme certain position. C. Instillity to samme certain position. (I. Instillity to samme certain position. (I. I. I. Have you cert been interest for a possible condition? (If yes, yes, yes, yes, yes, yes, yes, yes,		1	job or stay in school because of:		1	18. Have you ever had any illness or injury other than those already
C. Inability to assume certain passions. C. Inability to assume certain passions.		au				19. Have you consulted or been treated by clinics, physicians,
D. Onther modelar reasons (If yee, per reasons.) 14. Have you ever been resisted for a metal and condition? (If yee, state reason of popular, metal, or other reason? (If yee, pive date, and reason.) 15. Have you ever been desired life immune? (If yee, state reason of popular, metal, or other reason? (If yee, pive date, and reason.) 16. Have you have, or have you been advised to have, any opera- 17. Have you ever been a parket in any type of hospital? (If yee, get yee date, yee, yee date, give date, reason, give data), or desir reason? (If yee, give date, reason, give data), yee the parket yee yee them a parket in any type of hospital? (If yee, get yee data), yee the parket yee yee them parket in any type of hospital? (If yee, get yee yee yee them, where, why, and name of dector and complete address yee for yeeing, recompanies for extinsic plantile, or the reason, gives yee them, where, when, and what amount, when, why,) EXPLANATION, (IS 3-22 ABOVE) 1. Certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the heat of my knowledge. I authorize any of the dectorr, hospitals, or clinica mentioned above to furnish the Government a complete water yee for years yee for years of years and years of years of years and		1	C. Inability to assume certain positions.			than minor illnesses? (If yes, give complete address of doctor, hospital
14. Here you, ever been created for a mental condition? (If yes, projections)			D. Other medical reasons (If yes, give reasons.)			
Certify that I have reviewed the foregoing information supplied by ne and the it is true and complete to the best of my knowledge. I authorize any of the decirent, supplied by the I have reviewed the foregoing information supplied by ne and that it is true and complete to the best of my knowledge. I authorize any of the decirent, supplied actively. Certify that I have reviewed the foregoing information supplied by ne and that it is true and complete to the best of my knowledge. I authorize any of the decirent, supplied actively. Certify that I have reviewed the foregoing information supplied by ne and that it is true and complete to the best of my knowledge. I authorize any of the decirent, supplied actively. Certify that I have reviewed the foregoing information supplied by ne and that it is true and complete to the best of my knowledge. I authorize any of the decirent, supplied actively. Certify that I have reviewed the foregoing information supplied by ne and that it is true and complete to the best of my knowledge. I authorize any of the decirent, supplied actively. Certify that I have reviewed the foregoing information supplied by ne and that it is true and complete to the best of my knowledge. I authorize any of the decirent, supplied actively. Certify that I have reviewed the foregoing information supplied by ne and that it is true and complete to the best of my knowledge. I authorize any of the decirent, supplied actively. Certify that I have reviewed the foregoing information supplied by ne and that it is true and complete to the best of my knowledge. I authorize any of the decirent, supplied actively. Certify that I have reviewed the foregoing information supplied by ne and that it is true and complete to the best of my knowledge. I authorize any of the decirent supplied actively. Certify that I have reviewed the foregoing information supplied the foregoing information supplied actively. Certify that I have reviewed the foregoing information supplied to the foregoing inf						physical, mental, or other reason? (If yes, give date, and reason,
17. Have you ever been a patient in any type of hospital? (If yes, you') when, where, why, and name of dector and complete address of hospital? (If yes, you') when, where, why, and name of dector and complete address of hospital? (If yes, you') hospital. (If yes, you') hospital, you') has a more of dector and complete address of hospital. (If yes, you') hospital, you') has a more of dector, hospitals, or clinics mentioned above to hunds the Government a complete transcript of any medical record. Intrake Screening:					The same of Same of Same	of physical, mental, or other reasons? (If yes, give date, reason.
SCHAMATION: (#13-22 ABOVE)		All Committee of the Co	16. Have you had, or have you been advised to have, any opera- tions? (If yes, describe and give age at which occured.)		All the second s	and type of discharge whether honorable, other than honorable, for un- fitness or unsuitability.)
I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinic mentioned above to furnish the Government a complete transcript of my medical record. TYPED OR PRINTED NAME OF EXAMINEE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE MANGE STEPPING THE USE OF DRUGS OR ALCOHOL? OR ALCOHOL.		1	specify when, where, why, and name of doctor and complete address			for pension, or compensation for existing disability? (If yes,
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IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE TYPE AND EXTENT OF LIMITATION 23. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.) Ligally blind to Pelyl — bunch brown Duning to Stand nose property of the	JAUN	DICE	, BRUISES AND/OR MARKS, SWEATING, BODY DEFORM-	_		1410
HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE TYPE AND EXTENT OF LIMITATION						
23. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.) 1 Ligably blind to Dely - Signayore in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.) 2 Dinust Fig. 3 Starod nose pray 4 Coughs alot - from 5 Chionic - simus drawage 4 Pyed or Printed NAME of Physician or DATE, Signayore						
Jugally blind to Dely - bind bowth Dinust trs. Stand nose pray Coughs alot - binus drainage Chronic - Dinus drainage Peped OR PRINTED NAME OF PHYSICIAN OR DATE, I SIGNATURE						
2) sinustres. Steroid nose spray From Goughs alot - sinus drainage. Chronic - sinus drainage. Pyped QR PRINTED NAME OF PHYSICIAN OR DATE, / SIGNAPORE NUMBER OF	an _.	y add	litional medical history he deems important, and record any significant findings	ere.)		1
E) Chronic - Dinus chainage. (P) Chronic - Dinus chainage. (NIMBER OF	1)	l	igally blind to Oleye - sin	CL	B	mth
E) Chronic - Dinus chainage. (P) Chronic - Dinus chainage. (NIMBER OF	2)	Ð	inustits. Sterad nose	M	21	ay
YPED OR PRINTED NAME OF PHYSICIAN OR DATE, SIGNATORE NUMBER OF	3) L	uì	nus -	1		0
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The control of the co			PRINTED NAME OF PHYSICIAN OR DATE , / SIGNA	/ 1		

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Federal Bureau Of Prisons

	(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)															
1.	LAS1		FIRST NAME—MIDDLE NAM				2. REGIS	TER	NUN	MBER						
		W	ARD, Myros	<u>V</u>				59	67	7 ~0 8	34					
3.	PURI	OSE OF	EXAMINATION		4.	DATE (F EXAMINATION 5. EXAM	IININ	IG F	ACILITY						
		ſ	1.0			12										
			140	<u>.</u>		10				adelphi						
6. 5	TAT	EMENT	OF EXAMINEE'S PRESENT H	EALT	ΉA	ND MEI	CATIONS CURRENTLY USED	(Follo	ow by	descriptio	n of past history, if complaint arises)					
İ											· · · · · · · · · · · · · · · · · · ·					
ļ						1										
							FAIR"									
							4 401 K									
			·													
	7. HAVE YOU EVER (Please check each item) 8. DO YOU (Please check each item) (Check each item)															
YES	ES NO (Check each item) YES NO (Check each item) (Check each item)															
	Lived with anyone who had tuberculosis Wear glasses or contact lenses															
	Coughed up blood Have vision in both eyes															
	X Bled excessively after injury or tooth extraction X Wear a hearing aid															
	\mathbf{X}	Attemp	eted suicide			<u>-</u>			ĪΧ̈́	Stutter	or stammer habitually					
	X	Been a	sleepwalker						X	Wear a	brace or back support					
9. H	. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)															
YES	S NO DON'T (Check each item) YES NO DON'T (Check each item) YES NO DON'T KNOW (Check each item) (Check each item)															
	У		Scarlet fever		ΙV		Adverse reaction to serum drug		X		Epilepsy or fits					
	X		Rheumatic fever	↓	or medicine		\sum		Car, train, sea or air sickness							
	X		Swollen or painful joints	1	X	<u> </u>	Broken bones		l x	·	Frequent trouble sleeping					
	X		Frequent or severe headache		X	1	Tumor, growth, cyst, cancer		14		Depression or excessive worry					
	للأ		Dizziness or fainting spells	<u> </u>	X	<u> </u>	Rupture/hernia		Īχ		Loss of memory or amnesia					
У			Eye trouble		<u>Y</u>		Piles or rectal disease		IX		Nervous trouble of any sort					
			Ear, nose, or throat trouble	<u> </u>	Ϋ́		Frequent or painful urination		X		Periods of unconsciousness					
	X		Hearing loss		X.		Bed wetting since age 12		W		Have you ever had					
	Ý.		Chronic or frequent colds	<u> </u>	X		Kidney stone or blood in urine	1	ĮX.		homosexual contact?					
	X		Severe tooth or gum trouble		Σ.		Sugar or albumin in urine		X		Been exposed to AIDS					
X			Sinusitis		Х		VD-Syphilis, gonorrhea, etc.		IX		Alcohol Use (Excessive)					
	X		Hay Fever		X		Recent gain or loss of weight		X		Drug Use/Addiction					
	X		Head injury	<u> </u>	X		Arthritis, Rheumatism, or Bursitis		X		Marijuana					
\prod	Х		Skin diseases		X		Bone, joint or other deformity		X		Cocaine					
	y		Thyroid trouble		X		Lameness		X		Heroin					
	X		Tuberculosis		X		Loss of finger or toe		X		L.S.D.					
	X		Asthma		Х		Painful or "Trick" shoulder or elbow		X		Amphetamines					
\times	\perp		Shortness of breath	<u> </u>	X		Recurrent back pain				Others: (Specify)					
			Pain or pressure in chest		X		"Trick" or locked knee									
X			Chronic cough		\mathcal{L}		Foot trouble				Alcohol or drug					
	У		Palpitation or pounding heart		X		Neuritis		Y		Withdrawal Problems					
\Box	Ϋ́		Heart trouble		Х		Paralysis (include infantile)		П							
\Box	Y High or low blood pressure															
$oxed{\int}$	Y	- 1	Cramps in your legs					10. F	EMA	LES ONI	Y HAVE YOU EVER					
\Box	X	1	Frequent indigestion								Been treated for a female disorder					
\Box	$\overline{\Lambda}$	į	Stomach, liver, or intestinal trouble								Had a change in menstrual pattern					
	XI		Gall bladder trouble or gallstones					i			ARE YOU PREGNANT					
	XI	J	aundice or hepatitis								SUSPECT YOU ARE PREGNANT					
1. W	HAT	IS YOU	IR USUAL OCCUPATION?					12.	ARE T							
											12. ARE YOU (Check one) Right handed Left handed					
								تك	Kigh	nanded	Lett handed					

		CHECK EVER LEW AEC OF				
YES	s NO	CHECK EACH ITEM TES OK IN	J EVERY ITEM CH			BE FULLY EXPLAINED IN BLANK SPACE BELOW
	T	13. Have you been refused employment or be job or stay in school because of:		1 Ex	S NO	18. Have you ever had any illness or injury other than those already
	14)	A. Sensitivity to chemicals, dust, sunlight	it, etc.	}_	1/	noted? (If yes, specify when, where, and give details.)
	<u> X</u>	B. Inability to perform certain motions.			X	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other
	X	C. Inability to assume certain positions.	**) - (2型. <u> / -)</u>		/~,	than minor illnesses? (If yes, give complete address of doctor, hosp clinic, and details.)
		D. Other medical reasons (If yes, give rea	<u></u>		+	<u> </u>
	X	14. Have you, ever been treated for a mental specify when, where, and give details).			Х	20. Have you ever been rejected for military service because of physical, mental, or other reason? (If yes, give date, and reason, for rejections.)
	X	15. Have you ever been denied life insurance? and give details.)			[/	21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason,
	X	16. Have you had, or have you been advised to tions? (If yes, describe and give age at who	hich occured.)		X	and type of discharge whether honorable, other than honorable, for fitness or unsuitability.)
		 Have you ever been a patient in any type of specify when, where, why, and name of do of hospital.) 	of hospital? (If yes, octor and complete ad	ldress	x	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why
EXPI	LANA	ATION: (#13-22 ABOVE)			<u>/</u>	
			plied by me and that i	it is true and con lete transcript of	nplete i my n	e to the best of my knowledge. I authorize any of the nedical record.
	ED OR	PRINTED NAME OF EXAMINEE			NATUR	
		yron word				myron Way
INTAI	KE SC	CREENING:		TH	IERE I	BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS
INMA'	TE RI	ECEIVED FROM: COURT TRANSFER	P.V			COHOL?
OTHE	.R					
MEDI	CAL	STAFF'S COMMENTS AND OBSER	ERVATIONS: PLEA	ASE or		ATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL YES NO
DIREC	CT Y	OUR ANSWERS TO MENTAL-STATUS, P NCE, CONDUCT, STATE OR CONSCI	POTENTIAL SUICID	DE 213		ARRANGEMENTS HAVE BEEN MADE?
IAUNI	DICE,	, BRUISES AND/OR MARKS, SWEATING	NG, BODY DEFORM	ES, UM		INVANORATION OF THE PROPERTY O
		C. NOTE OBSERVATIONS IN BLOCK 23		and the second s		TATUS: TEMPORARY WORK RESTRICTED
		HAVE BEEN USED, NOTE TYPE, HOW		CH, GE	ENERA	AL POPULATION YES NO
		EN, HOW USED. WHEN WERE THEY				ND EXTENT OF LIMITATION
3. Phy	ysiciar •4di	a's summary and elaboration of all pertinent date	a (Physician shall com	nment on all pos	itive a	answers in item 6 through 22. Physician may develop by interview
	101	itional medical history he deems traportant, and r	record any significant	findings here.j		
2	Hex	ally wina to age	<i>;</i>			
(2)	M	t: Linusetro,	. 1.1	-		
3)(Oa	ecasional SOB E	rights	ne co	rej	A.
_			U		ļ	J
		,	•			
			— ···			•
YPED XAMIN		PRINTED NAME OF PHYSICIAN OR	DATE	SIGNATURE	***************************************	NUMBER OF
	·	į,	1	1		ATTACHED SHEETS

EVERSE

Case 1:04-cy-00011-SJM-SPB Document 46-8 ICAE HISTO Y REPORT 2 13 of 41 8/M/0/07-07-1970 HT/510 WT/150 HR/BN EY/BK CUSTODY/IN) MEDICALLY CONFIDENTIAL USE ONLY TO UNAUTHORIZED PERSONS) 2. REGISTER NUMBER 05967-084 5. EXAMINING FACILITY TION. **FCI CUMBERLAND** 6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint arises) 7. HAVE YOU EVER (Please check each item) 8. DO YOU (Please check each item) YES NO (Check each item) YES NO (Check each item) Lived with anyone who had tuberculosis Wear glasses or contact lenses Coughed up blood Have vision in both eyes Bled excessively after injury or tooth extraction Wear a hearing aid Attempted suicide Stutter or stammer habitually Been a sleepwalker Wear a brace or back support 9. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item) YES NO DON'T YES NO DON'T (Check each item) YES NO DON'T KNOW (Check each item) (Check each item) Scarlet fever Adverse reaction to serum drug Epilepsy or fits Rheumatic fever or medicine Car, train, sea or air sickness Swollen or painful joints Broken bones Frequent trouble sleeping Frequent or severe headache Tumor, growth, cyst, cancer Depression or excessive worry Dizziness or fainting spells Rupture/hernia Loss of memory or amnesia Eye trouble Piles or rectal disease Nervous trouble of any sort Ear, nose, or throat trouble Frequent or painful urination Periods of unconsciousness Hearing loss Bed wetting since age 12 Have you ever had Chronic or frequent colds Kidney stone or blood in urine homosexual contact? Severe tooth or gum trouble Sugar or albumin in urine Been exposed to AIDS Sinusitie VD-Syphilis, gonorrhea, etc. Alcohol Use (Excessive) Hay Fever Recent gain or loss of weight Drug Use/Addiction Head injury Arthritis, Rheumatism, or Bursitis Marijuana Skin diseases Bone, joint or other deformity Cocaine Thyroid trouble Lameness Heroin ¥ Tuberculosis Loss of finger or toe L.S.D. Asthma Painful or "Trick"shoulder or elbow **Amphetamines** Shortness of breath Recurrent back pain Others: (Specify) Pain or pressure in chest "Trick" or locked knee Chronic cough Foot trouble Alcohol or drug Palpitation or pounding heart Neuritis Withdrawal Problems Heart trouble Paralysis (include infantile) High or low blood pressure Cramps in your legs 10. FEMALES ONLY HAVE YOU EVER Frequent indigestion Been treated for a female disorder Stomach, liver, or intestinal trouble Had a change in menstrual pattern Gall bladder trouble or gallstones ARE YOU PREGNANT Jaundice or hepatitis SUSPECT YOU ARE PREGNANT 11. WHAT IS YOUR USUAL OCCUPATION? 12. ARE YOU (Check one) GlerK719151 Right handed Left handed

> 8P-360(60) JANUARY 1986

	CULTURE DE CONTROL CON			
	CHECK EACH ITEM YES OR NO EVERY ITEM CHECKE			BE FULLY EXPLAINED IN BLANK SPACE BELOW
YES NO	<u> </u>	YES	NO	
X	 Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc. 		X	18. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)
X	B. Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other
X	C. Inability to assume certain positions.		X	than minor illnesses? (If yes, give complete address of doctor, hospita clinic, and details.)
X	D. Other medical reasons (If yes, give reasons.)		<u> </u>	20. Have you ever been rejected for military service because of
Х	14. Have you, ever been treated for a mental condition? (If yes, specify when, where, and give details).		X	physical, mental, or other reason? (If yes, give date, and reason, for rejections.)
Х	15. Have you ever been denied life insurance? (If yes, state reason and give details.)		V	21. Have you ever been discharged from military service because of physical, mental, of other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for w
X	16. Have you had, or have you been advised to have, any opera- tions? (If yes, describe and give age at which occured.)		<u>/</u> ^.	fitness or unsuitability.)
X	17. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		X	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes. specify what kind, granted by whom, and what amount, when, why.)
EXPLANA	ATION: (#13-22 ABOVE)	· · · · · · · · ·		
				•
I certify the doctors, he	at I have reviewed the foregoing information supplied by me and that it is truespitals, or clinics mentioned above to furnish the Government a complete tra	te and con	nplete	to the best of my knowledge. I authorize any of the
	R PRINTED NAME OF EXAMINEE			
TIFED O	VIADA. MVOAN	SIGN	IATU A /	RE AND
INTAKE S	CREENING:	/_//	(N	PEEN ANY PROPERTY OF STRUCK STRUCK STRUCK STRUCK STRUCK
INMATE E	RECEIVED FROM: COURT TRANSFER P.V			BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OHOL?
OTHER				
		DO	ES P	ATTENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL
	STAFF'S COMMENTS AND OBSERVATIONS: PLEASE YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE,			YES NO
APPEARA	NCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES,	W	LAT A	RRANGEMENTS HAVE BEEN MADE?
ITIES, ET	E, BRUISES AND/OR MARKS, SWEATING, BODY DEFORM- C. NOTE OBSERVATIONS IN BLOCK 23 BELOW.	— DI		PARTY TRANSPORTER
	S HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH,			I POPULATIONYES NO
	TEN, HOW USED. WHEN WERE THEY LAST USED: HAVE			ND EXTENT OF LIMITATION
	ian's summary and elaboration of all pertinent data (Physician shall comment			
any ada	ditional medical history he deems important, and record any significant findin	on au pos 1gs here.)	uive i	nswers in item 0 inrough 22. Physician may develop by interview
	, - Kin			
Н	lave you ever been exposed to TB			A A
	lepatitis No Syphilis NO AIDS HOUS HOUS LOOK Seizures	Oxto	i u	1007 BID. # 5
	sthma Any current meds	· ''	-	' //
A	ny drug allergies <u>V</u> ⁵			
S	ick call explained			
r	III HIIC CAPIGIROU			
YPED OR		NATURE		NUMBER OF
XAMINER	AMYECI CUMBERLAND 4/21/99	h		ATTACHED SHEETS
EVERSE		<i>_</i>		

U.S. DEPARTMENT OF JUSTICE

=	(THIS	INFOR	MATION IS FOR OFFICIAL A	ND ME	DICAL	LY CON	IFIDENTIAL USE ONL	Y AND	MIL	L N	OT BE	RELEA	SED TO UNAUTHORIZED PERSONS)
1.	LAST	NAME -	FIRST NAME-MIDDLE NAME, MYCON - ARVEL				-	****	$\overline{}$			R NUMB	
3.	PURP	OSE OF	EXAMINATION			OF EXA	MINATION AA		5. Fe	EX/	MINI al Tr	NG FAC	ILITY Center, Oklahoma City, OK
6,	STATE	EMENT (OF EXAMINEE'S PRESENT HE	ALTH .				D (F	ollo	w by	/ des	cripti	on of past history, if
7.	HAVE	YOU EV	/ER (Please check each it	tem)				8.	DO YO	 DU (Plea	se che	ck each item)
YE	s NO		(Check e	each	item)			YES	T	T			(Check each item)
	X	Live	d with anyone who had to	bercu	ılosi	S		X	W	ear :	glasses	s or contact lenses	
	X	Coug	hed up blood				Y	╌			in both eyes		
	K	Bled	l excessively after injur	у ог	tooti	n extra	action		X	W	ear a	heari	ing aid
	1	Atte	mpted suicide						X	s	tutte	er or s	tammer habitually
	X	Been	a sleepwalker						X	We	ear a	brace	or back support
9.	HAVE	YOU EV	ER HAD OR HAVE YOU NOW (Pleas	e che	ck at	left of each item)					
YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each	tem)	,	YES	NO	DON'T	(Check each item)
	X		Scarlet fever		Х		Adverse reaction	to			γ		Epilepsy or fits
	X		Rheumatic fever		Х		drug or medicine				/		Car,train,sea or air sickne
	X		Swollen or painful		X		Broken bones				$\overline{\chi}$		Frequent trouble sleeping
	X		joints		X		Tumor, growth, cyst	, can	cer		X		Depression or excessive wor
			Frequent or severe		X		Rupture/hernia				X		Loss if memory or amnesia
<u>X</u>	ļ		headache		X		Piles or rectal d	iseas	se	7			Nervous trouble of any sort
	Х		Dizziness or fainting				Frequent or			,	X		Periods of unconsciousness
. 7	X		spells		X		painful urination			7			Have you ever had
χ			Eye trouble		X		Bed wetting since	age	12	/	X		homosexual contact?
	Χ		Ear, nose, throat trouble		X		Kidney stone or			_ /			Been exposed to AIDS
	X		Hearing loss		X		blood in urine)	/		Alcohol Use (Excessive)
	χ		Chronic, frequent colds		X		Sugar, albumin in	urin	e X	<u> </u>			Drug Use/Addiction
	X		Sever tooth, gum trouble	X			VD-Syphilis, gonor	rhea	,		χ		Mari juana
_	Х		Sinusitis				etc.			<u> </u> ,	X	- [Cocaine
	X		Hay Fever		X		Recent gain or los	s of	_		X		leroin
	X		Head injury		X		weight)		Į!	s.D.
_	λ	-	Skin diseases		X	,	Arthritis, Rheumat	ism,			<u> </u>	1	Amphetamines
	X		Thyroid trouble		XΪ		or Bursitis			\bot		0	Others: (Specify)
	K	1	Tuberculosis		X	ļ£	Bone, joint or						PCP
j	X	<i>j</i> ,	Asthma		x	C	other deformity		_	ĮΧ		Ā	lcohol or drug
	Χİ	s	Shortness of breath		х	L	ameness			$ _{\chi}$!	ļw	ithdrawal Problems
	t, J	7					· · · · · · · · · · · · · · · · · · ·				- -		

	Ca	<u>ase 1:04-cv-00011-SJ</u> M-SF	PB	D	ocument	t 46-8	}	Filed 02	/15	/200)6	Page 16 of 41
	_ X	Pain, pressure in Chest	{	X	Lo	ss of	inge	r or toe	T	ļ . ¯	_ ر	
	Χ	Chronic cough		X	Pa	inful o	r "T	rick"	+	†	 - -	1
	X	Palpitation or pounding		χ	sho	oulder	ог е	lbow	10.	FEMAL	ES ON	ILY HAVE YOU EVER
	χ	heart	X		Rec	urrent	baci	c pain	 	T		Been treated for a
	У	Heart trouble		V	"71	íck" o	r loc	ked knee	 	 	 	female disorder
	X	High or low blood	 	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Foo	t trou	ble		-	 	 	Had a change in
	X	pressure	 	X	Neu	ritis		-	-	 	-	menstrual pattern
	X	Cramps in your legs	-	X	Par	alysis	(inc	lude	 -			ARE YOU PREGNANT
	X	Frequent indigestion	 	7	 	antile					-	SUSPECT YOU ARE PREGNANT
	K	Stomach, liver, or		X	Ga	llblad	der	trouble or			-	SUSPECT TOO ARE PREGNANT
	X	intestinal trouble		<u> </u>	 	listone						
	X	Jaundice or hepatitis		X	J. J.							
11.	1 .	}			1 112	405 V6	4				· 	
		T IS YOUR USUAL OCCUPATION? (LC)		y ? .s	7 112.							d 🗌 Left handed
VEC	T 110	CHECK EACH ITEM YES OR	NO	EVERY	ITEM CHEC	KED YE	S MUS	ST BE FULLY	EXP	LAINE	D IN	BLANK SPACE BELOW
YES	NO				··· · · · · · · · · · · · · · · · · ·	YE	S NO)				
		13. Have you been refused emplo to hold a job or stay in sc	ymen hool	t or beca	been unabl use of:	e		/ 18. Have	you	ever	had	any illness or injury noted?
	X	A. Sensitivity to chemicals	, du	st, s	unlight, e	tc	+-	-				hen, where, and give details
	X	B. Inability to perform cer	tain	moti	ons.			phys	icia	ns, h	ealers	or been treated by clinics, s, or other practitioners
	X	C. Inability to assume certa	in positions.			hin the past 5 years for other than minor nesses? (If yes, give complete address of			, give complete address of			
	У	D. Other medical reasons (I	f ye	s, gi	ve reasons.	.>	1/	 				clinic, and details.)
		14. Have you, ever been treated	for	a mer	ntal	_		20. Have becau	you ise c	ever f phy	been sical	rejected for military service, mental, or other reason?
ļ	χ	condition? (If yes, specify give details).	wher	η, Whe	ere, and	ļ 	X	(If y	es,	give	date,	and reason, for rejections.
	٧	15. Have you ever been denied li	fe i	nsura	ance?			21. Have	you ce b	ever ecaus	been e of	discharged from military physical, mental, or other
	X	reason and give details.)	,		reasons? (If yes			es, g	give date, reason, and type			
		Kave you had, or have you been advised any operations? (If yes, describe and			ed to have,			honor	harge whether honorable, other than rable, for unfitness or unsuitability.)			
X	\	at which occurred.) Eye S			9ht Age 17			22. Have	you	ever	recei	ved, is there pending, or
İ		17. Have you ever been a patient	in	any t	ype of		have you applied for pension, or confor existing disability? (If yes, s			lity? (If yes, specify what		
	χΙ	hospital? (If yes, specify w name of doctor and complete	hen, addr	wher ess o	e, why, and f hospital	d -)	X	kind,	gra	nted i	by who	om, and what amount, when,
Lorta	fy tha	at I have severed the first										
	3- 4	at I have reviewed the foregoing information authorize any of the doctors, hospitals.	or c	ppinea linnes	mentioned abo	ve to ru	true a rnish	ind complete t the Governmen	o the t a co	best o	f my trans	cript of my medical record.
INTAKE		ITED NAME OF EXAMINEE WARD, MYRO	M-	SIGNA	7.07		WA	NCE STOPPING	TIE III		21122	
INMATE		/ED FROM: COURT TRANSFER P.V		_	OR ALCOHOL?	WI PROBL	C(15 51	NCE STOPPING	THE U	SE OF D	RUGS	_
DIHER _ MEDICAL	STAFF	'S COMMENTS AND OBSERVATIONS PLEASE		-	DOES PATIENT STAFF YES	NEED TO	≱ E SE	EN IMMEDIATEL	7 BY 7	HE MED	ICAL	•
VIRECI NPEARA	YUUR A NCE, C	NSWERS TO MENTAL STATUS, POTENTIAL SUICIDE ONDUCT, STATE OR CONSCIOUSNESS, RASHES, ISES AND/OR MARKS, SWEATING, BODY			WHAT ARRANGE	- 7	IE BEE	M-MADE?				
JEFURMI	HES.	ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.			DUTY STATUS:	TEMPORAL	RY WOR	RESTRICT	ΕĐ			•
IF UKUG:	S HAVE EN. HOI	BEEN USED. NOTE TYPE. HOW LONG. HOW MUCH. W USED. WHEN WERE THEY LAST USED: HAVE			GENERAL POPUL	ATION	YES	NO				• • •
Glin!	₩. @ (₩.299)	summary and elaboration of all pertinen of all medical history he degree impor	t dat tant	a (Phys	sician shall c	comment of	n all findir	positive answ igs here.)	ers 1	nitem	6 thro	ugh 22. Physician may develop by
YHE OF XAMENER	Ök	and of the rest of	5	1900	IRE	71	<u></u>	NUMBE	R OF	iffte		······································
.	F2-	and or Day OF			W.					برد کئ 		
	Cu	ood or Drug Mergies: We wirent Medical Status: No.	<u>e</u> o	Wbja Wile	rgies: ints: Co	mplai	nt c	of				

TB Signs and Symptom(s): NONE; cough, hemoptysis, night sweats, wt.los

BP-\$354.060 INTAKE SCREEN_A (MEDICAL) COFRM NOV 94

U.S.	DEPARTMENT	OF	JUSTICE

(Medical staff shall complete Institution)	e this screening	form on all arrivals to t	he
Institution FCC Peleisburg LOW	Date of Arrival	Time of Arrival	
Inmate's Name Word Muyon	Regist	er Number 907-084	<u> </u>
мері	CAL CLEA	RANCE	
1. BP-149(60) reviewed? ★ yes	s; 🛘 no (Explain)		
2. General Population Housing need)	J Approved? 总 yes	; □ no (Specify limitatio	n or
3. Approved for Temporary Wor or exclusions)	k Assignment? N	yes; O no (Specify limita	tions
4. For Holdovers: OK for Con	tinued Transport	? Vyes; O no (Explain)	
5. Disabilities? 🗆 yes 🕱 n	o (If yes, enter Code(s)	r code(s) into MDS)	
6. Remarks:			
Medical Staff Signature	Date 10/29	Time //03 //05.0m	
Medical Staff Title	F. Bailey, RN, PHS	1,00 pm	
Record Copy - Inmate Central H (This form may be replicated via WP)	File; copy - file	Penlaces BP. 35//40\ a4 ann	

Case 1:04-cv-00011-SJM-SPB Doo	cument 46-8 Filed 02/15/2006 Page 18 of 41
WARD	0-1
MYRON ARVEL 05967-084 B/M/O/07-07-1970	Pat
HT/509 WT/155 HR/BK EY/BN	FEDERAL BUREAU OF PRISONS
CUSTODY/IN	ening form on all arrivals to the
FCC Pem	
	rrival Time of Arrival
	1430
WARD MYRON ARVEL 05967-084	Register Number
MEDICAI	CLEARANCE
1. BP-149(60) reviewed? [] yes; []	no (Explain)
	(
2. General Population Housing Appr	roved? Tyes; T no (Specify limitation or
need)	remark gylen, n no (phecity limitation of
	:
3. Approved for Temporary Work Ass	signment? Dyes; Dno (Specify limitations
or exclusions)	January - Joseph Mark (Specify Himitations
· · ·	
4. For Holdovers: OK for Continue	ed Transport? G yes; G no (Explain)
,	sa rransport: d yes, d no (Explain)
5. Disabilities? yes no ()	If you contain code(-) into your
-	If yes, enter code(s) into MDS)
6. Remarks:	
o. Remarks:	
•	
Medical Staff Signature	Date Time 130
<u>Comeciors</u>	19/2/03
Medical Staff Title	To Part I
Medical Stail lifts	•
Record Copy - Inmate central File;	copy - file
(This form may be replicated via WP)	Replaces BP-354(60) of APRIL 1990
	and BP-S354 of AUG 1994

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Filed 02/15/2006 Page 19 of 41

BP-S354.060 INTAKE SCREEN1. IEDICAL)

NOV 94 U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

(Medical staff shall complete this s Institution)	creening form o	n all arrivals to the
Institution Date of	of Arrival	Time of Arrival
Inmate's Name Myron	Register Num	767-084
MEDICAL	CLEARAN	CE
1. BP-149(60) reviewed? Yes; 🗆 no	(Explain)	
2. General Population Housing Approvinced)	ved? d yes; □ no) (Specify limitation or
 Approved for Temporary Work Assic or exclusions) 	gnment? yes; [no (Specify limitations
•	no As-	
4. For Holdovers: OK for Continued	Transport? / ye	es; 🛘 no (Explain)
	yes, enter code e(s)	e(s) into MDS)
6. Remarks: Medications Allergies Lice Suicidal Ideation		
Medical Staff/Signature	Date 10/20/6	Time /8/5
Medical Staff Title	NP-C.	
Record Copy - Inmate Central File;	copy - file	

(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990 and BP-S354 of AUG 1994



BP-S354.060 INTAKE SCREENING (MEDICAL) CDFRM NOV 94

TT C	מתוכות ותוכות לו יכול	\sim	
U.D.	DEPARTMENT	OF	JUSTICE

(Medical staff shall comp Institution)	lete this screen	ning form on a	ll arrivals to the	
Institution	Date of Arri	val	Time of Arrival	
U.S.P.LEWISBURG, PA	SBURG, PA OCTOBER 17,2003 1300			
Inmate's Name		Register Numb	per	
WARD , MYRO	N	05967	- 084	
	EDICAL	CLEAREN	CE	
1. BP-149(60) reviewed?	∰ yes; ⊔ no (Exp	olain)		
2. General Population Houneed)	sing Approved?	g yes; □ no (s	Specify limitation or	
4. For Holdovers: OK for	Continued Trans	port? 💆 yes; 🗆	no (Explain)	
5. Disabilities? 🗆 yes 🏿	no (If yes, en Code(s)	ter code(s) in	to MDS)	
6.Remarks:				
· · · · · · · · · · · · · · · · · · ·				
Medical Staff Signature	Date	OBER 17,2003	Time 1415 HRS.	
Medical Staff Title FERDI				
ecord Copy - Inmate Centre	al File; copy -	file		
his form may be replicated via	WP) Replace	BP-354(60) of API	RIL 1990 and BP~S354 of AUG 199	

BP-\$354.060 INTAKE SCREENIA (MEDICAL) NOV 94 U.S. DEPARTMENT OF JUSTICE

CÐFRM

(Medical staff shall comp Institution)	plete this scr	eening form or	all arrivals to the
Institution MCKean	Date of -1/20/6	Arrival	Time of Arrival
Inmate's Name Ward, Myro	η	Register Numb	oer - 084
МЕ	DICAL	CLEARAN	CE
1. BP-149(60) reviewed? [yes; □ no (E	xplain)	
2. General Population Houned)	·		
 Approved for Temporary or exclusions) 	y Work Assignm	ent? 🛛 Yes; 🗈	no (Specify limitations
4. For Holdovers: OK for	Continued Tr	ansport? D yes	; □ no (Explain)
5. Disabilities? 🛚 yes	no (If ye Code(s	s, enter code(s) into MDS)
6. Remarks:	Blind (e)	eye	
Medical Staff Signature		Date 7(20(0)	Time /245
Medical Staff Title Cheryl Lundberg, RN			
Record Copy - Inmate Cent This form may be replicated via WP)	ral File; copy	y - file	Replaces BP-354(60) of APRIL 1990 and BP-S354 of AUG 1994

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

(Medical staff shall complete this screening for Institution) Institution USP LEWISBURG Health Services Unit	m on all arrivals to the
Institution USP LEWISRUPC	
Health Com Date of Arrival	
TICALLE NORMAN ILLA	Time of T
Health Services Unit Lewisburg, PA 17837 Health Services Unit 7/3/0/	Time of Arrival
Inmate's Name	1815
(1)(2) (1) Register	Number
- Wall Muron Agual Or	5 0x7-08/1
MEDICAL CLEAR	7907 084
1. BP-149(60) residence to a	NCE
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) (Consum)	
2. General Population Housing Approved?	70 /5- : 6
need) red; Tyes; D	no (Specify limitation of
. Approved for man	
. Approved for Temporary Work Assignment? Tyes; or exclusions)	Π no (S== :6
or exclusions)	O no (Specify limitatio
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For Holdovers: OK for Continued Transport?	/
	788 · 🖺 ¬^ / ¬
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Replaces BP-354(60) of APRIL 1990 and BP-S354 of AUG 1994



BP-S354.060 INTAKE SCREENING (MEDICAL) COFRM

U.S.	DEPARTMENT	OF	JUSTICE
· · ·	DAR WILLIAM T	OT.	COTION

(Medical staff shall complete Institution)	ete this screening	form on all arrivals to the
Institution FC1 Consto	Date of Arrival	Time of Arrival
Inmate's Name WARD, MYRON		er Number 5967-084
мер	I C A L C L E A	RANCE
1. BP-149(60) reviewed?	ves; □ no (Explain)	
2. General Population Housi need)	ing Approved? V yes	; [] no (Specify limitation or
3. Approved for Temporary W or exclusions)	Work Assignment?	yes; no (Specify limitations
4. For Holdovers: OK for C	ر م	? 🛘 yes; 🖟 no (Explain)
5. Disabilities? 🗆 yes	no (If yes, ente Code(s)	r code(s) into MDS)
6. Remarks:		
	and the second of the second o	
Medical Staff Signature	Date /-	3-0/ Time /////
Medical Staff Title		
Record Copy - Inmate Centra (This form may be replicated via WP)	al File; copy - fil	e Replaces BP-354(60) of APRIL 1990 and BP-8354 of AUG 1994

BP-S354.060 INTAKE SCREEN1 # (MEDICAL) COFRM

NOV 94

U.S. DEPARTMENT OF JUSTICE

(Med:	ical staff shall complete this screening form on all arrivals to the itution)
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Inn	HT/51Ø WT/15Ø HR/BN EY/BK Register Number CUSTODY/IN
	MEDICAL CLEARANCE
1. BE	P-149(60) reviewed? Dyes; D no (Explain)
2. Ge ne	eneral Population Housing Approved? Tyes; I no (Specify limitation or eed)
4. Fo	or Holdovers: OK for Continued Transport? yes; no (Explain)
5. Di	sabilities? Dyes one (If yes, enter code(s) into MDS) Code(s)
5. Re	emarks:
1edic	Time 258
1edic	al Staff Title
tecor	d Copy - Inmate Central File; copy - file rm may be replicated via WP) Replaces BP-354(60) of APRIL 1990 and BP-3554 of AUG 1994

BP-\$354.060 INTAKE SCREENING (MEDICAL) COFRM NOV 94

U	. 5 .	DEPARTMENT	OF	JUSTICE

(Medical star Institution)	ff shall com	plete this	scree	ning f	orm on	all arrivals	to the
Institution	FCI Cumberla	nd Date	of Ar 4-26	_		Time of Arr	ival
Inmate's Name) Yron		R		r Number	,	
	ME	D I C A L	CI		ANC		
1. BP-149(60)	reviewed? [] yes; 🗗 n	o (Exp	lain)		-	
		5+6					
2. General Poneed)	opulation Hor	using Appr	oved?	∡yes;	□ no (8	Specify limit	ation or
3. Approved for exclusi 4. For Holdov	·		No :	F/s			
5. Disabiliti	es? 🛘 yes		f yes, de(s)	enter	code(s)	into MDS)	
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6. Remarks:		*	``	1.			·
	•	N. Carlotte	f w	·	SCRE ESSEI	ENED FOR LICE VITALLY HEALTHY I	<i>n</i> ale
Medical Staff	Signature	: · · · ·	Dā	te 4-26	79	Time	
Medical Staff		ard Klimkiewi JMBERLAND	cz, PA-C				
Record Copy - (This form may be repl	Inmate Cent	ral File;	copy -	file		Replaces BP-354(60 and BP-S354 of AUG	

Case 1:04-cv-00011-SJM-SPB Document 46-8 Filed 02/15/2006 Page 26 of 41 BP-S354.060 INTAKE SCREENING (MEDICAL) NOV 94 U.S. DEPARTMENT OF JUSTICE WARD DDISONS MYRON ARVEL 05967-084 (Medical staff shall complete B/M/O/07-07-1970 10 Institution) HT/510 WT/150 HR/BN EY/BK CUSTODY/IN Institution Inmate's Name MEDIC BP-149(60) reviewed?

 □ yes; □ no (Explain) 2. General Population Housing Approved? \square yes; \square no (Specify limitation or need) 3. Approved for Temporary Work Assignment? yes; no (Specify limitations or exclusions) 4. For Holdovers: 5. Disabilities? □ yes □ no (If yes, enter code(s) into MDS) Code(s)

6. Remarks:

Medical Staff Signature

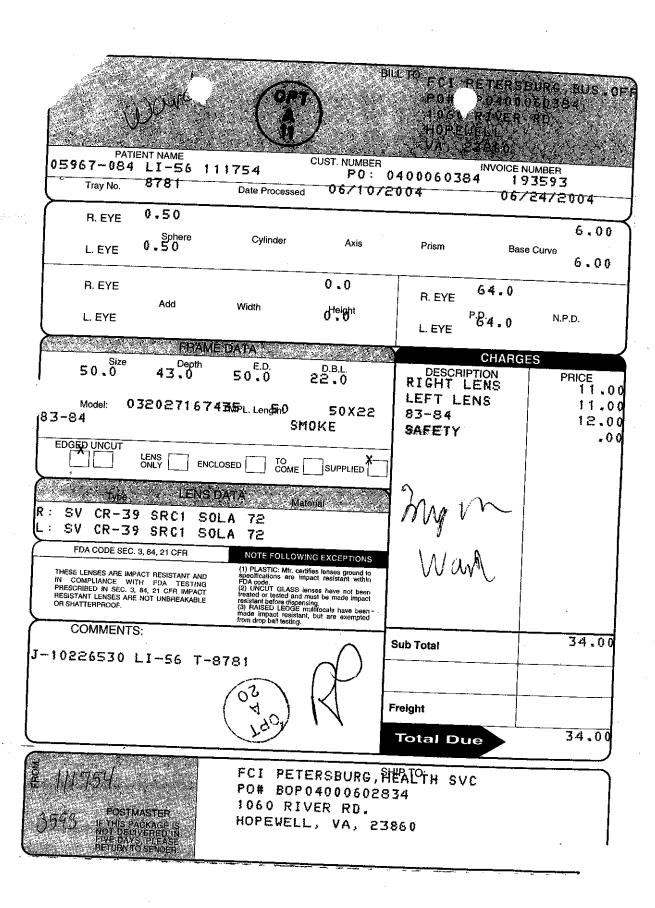
Date APR 05 1999

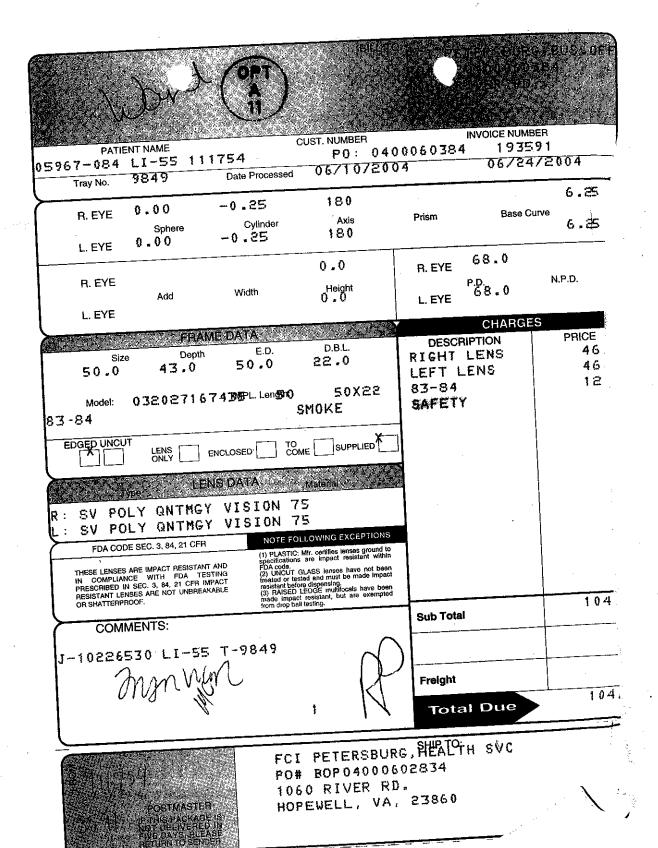
Medical Staff Title

Todd Genzei Record Copy - Inmate Central Ning; copy - file (This form may be replicated via WP) TC, Oklahoma City, OK

Replaces BP-354(60) of APRIL 1990 and BP-S354 of AUG 1994







313-111		AUTH	ORIZED FOR LOCAL REPRODUCTION
MEDICAL RECORD	CONSUL	TATION SHEET	2 OF LOCAL REPRODUCTION
		TATION SHEET	
TO:	REQUEST		
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REASON FOR REQUEST (Complains and findings)	- D. Mayor	surn M.D	15-20-04
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PROVISIONAL DIAGNOSIS		· · · · · · · · · · · · · · · · · · ·	
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DOCTOR'S SIGNATURE	APPROVED PLACE OF C	ONSULTATION	
V. Regan RN			ROUTINE TODAY
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	CONSULTATION REPORT		Next West
RECORD REVIEWED YES NO	PATIENT EXAMINED YES	S NO TEL	EMEDICINE YES NO
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OSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SER	UCE OF PATIENT
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		5. 5.1.50	11 3 10 HOMBER (33N of Other)
ATIENT'S IDENTIFICATION (For typed or written entries give: N	lame-last, first, middle; ID no. (SSN or other); Sex: Date of Birth	REGISTER NO.	WARD NO.
. Rank/Grade)	, , , , , , , , , , , , , , , , , , , ,		WARD IYU.
O.n.			
Ward, Myrin	F.C.I. Petersburg		•
100	Health Services Unit Petersburg, VA 23804		
Ward, Myron 05967-084	<i>∞ ⋅ </i>	CONSULTA	TION SHEET
- 0 1		Medic	al Record
	•	STANDARD FORM	513 (REV. 4-98)
		Prescribed by GSA/ICMI	R FPMR (41 CFR) 101-11 .203(b)(10)

Case 1:04-cv-00011-SJM-SPB Document 46-8 Filed 02/15/2006 Page 29 of 41

Ward, Neym

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CONSULTATION SHEET

Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

, Case 1:04-	cv-00011-SJM-S	SPB Docume	nt 46-8	Filed 02/	15/2006	Page 31	of 41	
513-110						NSN 7	540-00-634-4127	
MEDICAL RECORD	· · · · · · · · · · · · · · · · · · ·		CONSULTAT	ION SHEET			つついつ	
	_1	RE	QUEST				U u a	-
: general surgery: I	or Rayudu	FRO	M: (Reques Laybourn	ting physic	ian or activ	ity) DAT 20-2004	Æ	
REASON FOR REQUEST (Co	omplaints and findi	ngs)						
33 yo male was evalo He was evalo be performed	with h/o bilate lated by genera d to r/o lympho	eral cervical al surgeon who oma.	lymph nod recomme	des and a nded that	xillary l lymph no	ymph node de biopsi	s. es	
PROVISIONAL DIAGNOSIS	Cervical	lymphadenopathy						
DOCTOR'S SIGNATURE On K. Laybourn, M. [mailing Officer [mailing]	I.D. Kno	PROVED	Dr. J. Alle Clinical D FCC Peter	irector	<u>x</u>	ROUTINE ASAP 1 MONTH 2-3 WEEKS OTHER		
1 - 1 2 (2 1 2 2 2 4 2 4 1 1 1 1 1 1 1 1 1 1 1 1	-9	CONSU	LTATION REF	PORT				
	•	(Continue on	ı reverse si	.de)				
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SIGNATURE AND TITLE						DAID	·	•
IDENTIFICATION NO.	ORGANIZATION		REGISTER N	0.				

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; rank; hospital or medical fac

STANDARD FORM 513 (REV. 8-92) Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

NAME: Ward, Myron #005967-084

DATE OF BIRTH:

13-111				AUTHORIZED FOR LO	CAL REPRODUCTION
MEDICAL RECORD		COI	NSULTATION SH	IEET	
		REQUEST	**		
o: Jungan	F	ROM: (Requesting phys	ician or activity) CU	DATE OF F	
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	. (ONSULTATION R		, , , , , , , , , , , , , , , , , , ,	
RECORD REVIEWED YES	NO PA	ATIENT EXAMINED	∐ ÝES ∐ NO	TELEMEDICINE	YES NO
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Control of the contro	On Hela	of Glenor	regaly .	CO Wi Cay	l lymph
SIGNATURE AND THE EIGHT SOURS	inginia (Continue on rever	se side)	R/O,	DATE HOME
HOSPITAL OR MEDICAL FACILITY	(. AECORDS	MAINTAINED AT	DEF	PARTMENT/SERVICE OF PAT	IENT
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RELATION TO SPONSOR	SPONSOR'	S NAME (Last, first, mid	ddle)	SPONSOR'S ID NUM	BER (SSN or Other)
Rank/Grac	,	ddle; ID no. (SSN or other); S	ex; Date of Birth: REGISTER	NO.	WARD NO.
9596708 FCC	ref Lon		STANI Prescrit	CONSULTATION SH Medical Record DARD FORM 513 (REV Ded by GSA/ICMR FPMR (41	

Department of Justice Federal Bureau of Prisons FCI - Petersburg Petersburg, Virginia

UTILIZATION REVIEW CHECKLIST

wane: Wasd, My	IM z	Reg #:	Date:
Diagnosis/Impression		003967-094	1-20-04
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How long has the condition existed?	÷ y	C	
Describe Prior	BIEL	0 01	
evaluation and treatment.	S	n seusjer	
Degree of disability			
Release date	**************************************	uld	·
	7-1	0-18	
Compliance with prior reatment			
Other comments		······································	
Dr. J. Allen Chinical Din FCC Peters	ector	Disapproved	**************************************
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C. Mendőza Jealth Services Adn Cason for action:	ninistrator	A. W. O.	1/2-1/7
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	**************************************	**************************************	*

513-111	AUTHORIZED FOR LOCAL REPRODUCTION
MEDICAL RECORD	CONSULTATION SHEET
	REQUEST
TO: (144 COMP)	FROM: (Requesting physician or activity) DATE OF REQUEST
REASON FOR REQUEST (Complaints and findings)	17/3/10-3
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Dr. K Laybourn, M.D. Dr. K Laybourn, M.D. SIGNATURE MARTIE ASSUES. Virginia	Recummengate: Corrical hymps
Dr. K Laybour Virginia	(Continue on reverse side)
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ATIENT'S IDENTIFICATION (For typed or written entries give: N.	ame-last, first, middle; ID no. (SSN or other); Sex; Date of Birth: REGISTER NO. WARD NO.
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05967084 ECCPet L	FCC Petersburg, Virginia CONSULTATION SHEET Medical Record
FCCIM	STANDARD FORM 513 (REV. 4-98) Prescribed by GSA/ICMR FPMR (41 CFR) 101-11, 203/b/(10)

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	Optometrist -		Dennis O	lg physician or activit lsoπ, MD, (n CHP	DATE OF F	REQUEST
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			~~~	Date: 6 //8	12	• • •	

Case 1	::04-cv-00011-SJM-SPE	FRO VII. REQUESTING	146-8 Filed shysician or activity) Son, MD, CHF	- <del>02</del> /15/2 <del>006</del> -	Page 36	of 41
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SPECIAL INSTRUCTIONS

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Case 1:04-cv-0 Souts JM SPRegional Medical Center 2/15/2006 Page 40 of 41

JOI South Adams Street
Petersburg, VA 23803

OPERATIVE REPORT

OF 967-084

Name: WARD, MYRON A

Room: O-SOP

MR#: 511619

Pt#: 6621654 Adm: 05/20/2004 DOB:

07/07/1970

Age: 33 Y Sex:

М

Disch: 05/20/2004

Adm Dr. RAYUDU, JUJJAVARAPU

Ord Dr: Dict:

Trans:

05/20/2004 13:09:04 05/20/2004 14:36:49

**Finalized Upon Physician Signature**

DATE OF OPERATION: 05/20/2004

PREOPERATIVE DIAGNOSIS: Cervical lymphadenopathy.

POSTOPERATIVE DIAGNOSIS: Cervical lymphadenopathy especially in the posterior triangle of the neck on the right side.

PROCEDURE PERFORMED: Lymph node biopsy from the posterior triangle of the right side of the neck.

SURGEON: JUJJAVARAPU RAYUDU, MD

ANESTHESIA: Local, 1% Lidocaine, 0.5% Marcaine, 1/2 and 1/2 combination prepared.

PLACE PERFORMED: Operating room.

HISTORY: This 33-year-old male presented with slightly enlarged lymph nodes along the posterior aspect of the neck, especially the right side. There is no evidence of any infection in the scalp or any areas of the head and neck. He is scheduled for a biopsy of this cervical lymph node.

PROCEDURE: The patient was placed supine on the table. The head was slightly elevated. Local

(Continued on next page.)

### Case 1:04-cv-0**Soutbo**M¹SP**Regional Medical Center**02/15/2006 Page 41 of 41

J01 South Adams Street Petersburg, VA 23803

### OPERATIVE REPORT

Name: WARD, MYRON A

Room: O-SOP

Pt#:

MR#: 511619 6621654 Adm: 05/20/2004

DOB: 07/07/1970

33 Y

Age: Sex: М

Disch: 05/20/2004

Adm Dr: RAYUDU, JUJJAVARAPU

Trans:

Ord Dr:

Dict:

05/20/2004 13:09:04 05/20/2004 14:36:49

**Finalized Upon Physician Signature**

anesthesia was infiltrated in the skin and subcutaneous tissues along the posterior aspect of the right side of the neck over the palpable lymph node. The transverse incision was given along this area. The platysmas muscle was incised along the line of the skin incision. The skin incision was made about 1inch in length. After opening the platysmas muscle, the dissection was continued along the posterior aspect. The trapezius muscle was identified. It was careful preserved. There is a lymph node, which is visible and very close to this nerve. It is carefully preserved, and the lymph node is dissected from this structure carefully. The specimen was sent for histopathological examination. Hemostasis was completely secured. The platysmas was approximated with 4-0 Monocryl continuous suture. The skin was closed with 4-0 Monocryl subcuticular continuous suture. Dry foam dressing was applied. The patient tolerated the procedure well. Transferred to the recovery room in satisfactory condition.

81503179 / 96531

Signed: ___

cc: DR ALLEN AT FCI LOW PRISON

Dictated By: JUJJAVARAPU RAYUDU MD/TRA Transcribed by TRA, 05/20/2004 14:36:49

Page: 2